Complete Health & Chiropractic Center
301 Oxford Valley Road, Suite 1601A
Yardley, PA 19067
215-369-0320

Complete Health of Lawrenceville
136 Franklin Corner Road
Lawrenceville, NJ 08648
609-912-0440

CONSENT FOR CHIROPRACTIC TREATMENT &

LIMITED AUTHORIZATION AND RELEASE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the chiropractic physician and/or anyone working in these offices authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the current chiropractic physicians and/or any other physicians of chiropractic who may treat me in the future at these offices.

I have had the opportunity to discuss with my doctor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, soreness, sprains, and physical therapy burns. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts known.

I authorize payment of insurance benefits directly to either of the offices listed above. I understand and agree to allow this office to use my confidential Patient Health Information (PHI) forms for the purpose of treatment, payment, healthcare operations, and coordination of care and thereby authorize the offices listed above to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have also read, or have had read to me the above informed consent, authorization, and release. I have had an opportunity to ask any and all questions about its content and, by signing below, I agree to the above named procedures. I intend this consent for to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment at these offices.

To be completed by the patient's representative, if necessary
(eg: if the patient is a minor, if the patient does not speak English, or if the patient is physically or mentally incapacitated)

_____ _____

Print Patient's Name ***Print Name of Representative***

_____ _____

Signature of Patient ***Signature of Representative***

_____

Date